Table 1. New York State Hospital Closures since 1983

Hospital Name	County	Year Closed
Brunswick Hospital Center*	Suffolk	2005
New York United Hospital	Westchester	2005
St. Vincent's Catholic Medical Center – St. Mary's	Kings	2005
The Hospital	Delaware	2005
St. Vincent's Catholic Medical Center – Bayley Seton	Richmond	2005
Our Lady of Mercy Medical Center – Florence D'Urso Pav	Bronx	2004
St. Vincent's Catholic Medical Center – St. Joseph's	Queens	2004
Beth Israel Medical Center – Singer Division	New York	2004
Staten Island University Hospital – Concord Div	Richmond	2003
Myers Community Hospital	Wayne	2003
Brooklyn Hospital Center – Caledonian Campus	Kings	2003
Interfaith Medical Center – Jewish Hospital of Brooklyn	Kings	2003
Mary McClellan Hospital	Washington	2003
Island Medical Center	Nassau	2003
St. Agnes Hospital	Westchester	2003
Amsterdam Memorial*	Montgomery	2002
Olean General Hospital*	Cattaraugus	2001
Genesee Hospital	Monroe	2001
Massapequa General Hospital	Nassau	2000
St. John's Episcopal Hospital, Community Div	Suffolk	1999
New York Flushing Hospital Medical Center – North Div	Queens	1999
St. Mary's Hospital	Monroe	1999
Lady of Victory – Lackawanna	Erie	1999
Union Hospital of the Bronx	Bronx	1998
Salamanca	Cattaraugus	1998
Columbus Community Healthcare	Erie	1998
Leonard Hospital	Rensselaer	1997
Samaritan Medical Center – Stone Street Div	Jefferson	1997
Mohawk Valley General	Herkimer	1996
Julia Butterfield Memorial	Putnam	1996
Wyckoff Heights Hospital – Jackson Heights Div	Queens	1996
Flushing Hospital – Little Neck Div	Queens	1996
Westchester Medical Center – Mental Retardation Institute	Westchester	1995
Medical Arts Center Hospital	New York	1994

Table 1 (continued). New York State Hospital Closures since 1983

Hospital Name	County	Year Closed
Mercy Hospital	Jefferson	1993
Greene Division – Columbia-Greene Medical Center	Greene	1993
St. Francis	Erie	1992
Waterloo Memorial – Taylor Brown	Seneca	1991
Adirondack Regional	Saratoga	1991
Salamanca	Cattaraugus	1991
Tioga General	Tioga	1990
Community	Delaware	1989
Holy Family Medical Center	Kings	1989
Arnold Gregory	Orleans	1989
Emma Laing Stevens	Washington	1989
Childrens	Oneida	1988
Jamestown General	Chautauqua	1988
Doctors Sunnyside	Orange	1988
Parsons	Queens	1988
Johnstown	Fulton	1988
Baptist Medical Center	Kings	1987
Long Island Jewish – Manhasset Division	Nassau	1987
Sheridan Park	Erie	1987
Deaconess Division – Buffalo General	Erie	1987
Seneca Falls	Seneca	1986
Flatbush General	Kings	1986
Lafayette General	Erie	1986
Bethesda	Steuben	1986
Cohoes Memorial	Albany	1986
Tuxedo Memorial	Orange	1985
Lydia E. Hall	Nassau	1985
Boulevard	Queens	1985
Prospect	Bronx	1985
Ideal-United Health Services	Broome	1984
Herkimer Memorial	Herkimer	1984
Terrace Heights	Queens	1984
Cumberland	Kings	1983
Jewish Memorial	New York	1983
Rose	Oneida	1983

* Brunswick Hospital – closed all medical-surgical beds, but maintain rehabilitation services, Amsterdam Memorial – closed emergency department, ICU and ceased using medical-surgical beds in 2002, in 2005 received approval to reopen inpatient beds. The beds are used for sub-acute care in connection with their nursing home, Olean General – services consolidated at main Olean General site and still in operation.
Source: New York State Department of Health

Table 2. New York State Nursing Home Closures since 1983

Nursing Home Name	County	Year Closed
Childs Nursing Home Company	Albany	2006
Cedar Hedge Nursing Home	Clinton	2006
Episcopal Residential Health Care Facility	Erie	2006
The Hospital Skilled Nursing Facility	Delaware	2005
Sunrest Health Facilities	Suffolk	2005
New York United Hospital Medical Center Skilled Nursing Pavilion	Westchester	2005
Hebrew Home For The Aged At Riverdale Baptist Div	Bronx	2005
Rehab Institute Of New York At Florence Nightingale Health Center	New York	2005
Menorah Home & Hospital For Aged And Infirm	Kings	2005
Kresge Residence	Erie	2004
Hutton Nursing Home	Ulster	2004
Manor Oak Skilled Nursing Facilities	Chautauqua	2004
St Lukes Manor Of Batavia	Genesee	2004
Manor Oak Skilled Nursing Facilities	Erie	2004
Loeb Center Montefiore Medical Center	Bronx	2004
Norloch Manor	Monroe	2004
Bethel Methodist Home	Westchester	2003
Wesley-On-East	Monroe	2003
Mary McClellan Skilled Nursing Facility	Washington	2003
Mt St Mary's Long Term Care Facility	Niagara	2003
Eden Park Health Care Center	Columbia	2003
Potsdam Nursing Home	St Lawrence	2003
St Mary's Manor	Niagara	2003
Manor Oak Skilled Nursing Facilities Inc	Wyoming	2003
The Gardens At Manhattan Health And Rehabilitation Center	Erie	2003
Eden Park Health Care Center	Albany	2003
St Clare Manor	Niagara	2003
Williamsville View Manor	Erie	2003
Lyden Care Center	Queens	2002
Genesee Hospital ECF	Monroe	2002
Our Lady of Victory/Head Trauma Unit	Erie	2002
Chandler Care Center	Westchester	2002
The Waters of Syracuse	Onondaga	2002
Beechwood Sanitarium	Monroe	2000
Dover Nursing Home	Kings	2000
Niagara Lutheran Delaware Home	Erie	1999

Table 2 (continued). New York State Nursing Home Closures since 1983

Nursing Home Name	County	Year Closed
Oswego Hospital ECF	Oswego	1999
Dutchess County HCF	Dutchess	1999
Leisure Arms	Rensselaer	1997
Eden Park Nursing	Rensselaer	1997
Broadacres	Oneida	1996
Madonna Residences, Inc	Kings	1995
Franklin Plaza Nursing Home	Nassau	1994
Catherine McAuley Manor	Erie	1993
Swiss Home Health Related Facility	Westchester	1993
St. Mary's Hospital Brain Injury Unit	Monroe	1992
Maryknoll Nursing Home	Westchester	1991
Gerrit Smith Memorial Infirmary	Madison	1991
Taylor-Brown Memorial Hospital Nursing Home	Seneca	1990
Good Samaritan Nursing Home	Albany	1990
Elcor's Marriott Manor Health Related Facility	Chemung	1990
Arnold Gregory Memorial Hospital Skilled Nursing Facility	Orleans	1989
Strong Memorial Hospital Skilled Nursing Facility	Monroe	1988
Chenango Bridge Nursing Home	Broome	1988
Placid Memorial Hospital	Essex	1988
Surfside Nursing Home	Queens	1988
City Hospital at Elmhurst Public Home	Queens	1988
St. George Nursing Home	Erie	1988
Margaret-Anthony Nursing Home	Chautauqua	1988
House of the Holy Comforter	Bronx	1986
Flower City Nursing Home	Monroe	1985
Jewish Home & Infirmary of Rochester	Monroe	1985

Source: New York State Department of Health

Health care facilities close for a variety of reasons, and rarely close due to one isolated cause. Common factors that lead to closures include:

- **Poor financial health**: First and foremost, facilities close due to lack of funds. As the adage indicates, "no margin, no mission." Not surprisingly, hospitals and nursing homes that close tend to have been in severe financial distress for an extended period of time before closing.

- **Aging physical plant**: Nationally, the average age of a hospital physical plant in 2004 was 9.8 years.[4] In New York, the Dormitory Authority for the State of New York (DASNY) estimates that the average age of a New York hospital in 2004 was approximately 12.5 years. Nationally, the biggest increases in capital expenditures have occurred in regular fixed equipment, meaning that hospitals have concentrated on repairs and renovations rather than design and construction of new facilities.[5]

- **Aging physical plant for nursing homes**: According to officials at the Department of Health, the majority of nursing homes in New York State were built before 1960. From the information available, the median year at which facilities began operating as nursing homes is 1971, but many facilities operate in buildings much older, built for purposes other than nursing homes and later converted.

- **Low occupancy rates:** An empty bed does not generate revenue. Even when a bed is unoccupied, there are significant fixed costs associated with maintaining that bed, including staffing and capital costs. Unoccupied beds are significant money drains on hospitals and nursing homes. Low occupancy rates can also indicate that facilities are unnecessary or undesirable; empty beds can reflect choices by patients and physician to seek and provide care elsewhere.

- **Poor community reputation:** All hospitals and nursing homes are community institutions, serving and served by people in the community. Those facilities with reputations as providers of high-quality care and as "good citizens" attract the area's physicians and patients. A good reputation therefore generally sustains a higher occupancy rate and a poor one helps sink an institution.

- **Weak management/leadership:** A critical factor to any successful hospital and nursing home is strong and efficient management and leadership. Management is responsible for

[4] American Hospital Association, (2006). Chartbook: Trends Affecting Hospitals and Health Systems, April 2006. Retrieved July 24, 2006, from the American Hospital Association Web site: http://www.aha.org/aha/research-and-trends/health-and-hospital-trends/2006.html

[5] Runy, L. (2003).Penny wise? Financial pressures force a short-term mind-set in capital spending. *Health Facilities Management*. *16(2)*, 20-21.

establishing and implementing a strategic plan that is in keeping with an organization's mission. Health care leaders should create a sense of organizational commitment, and provide a supportive work environment to help to prevent/protect against burnout, which will ultimately reduce employee turnover and save money.[6]

According to the Healthcare Financial Management Association, rating agencies such as Moody's and Standard and Poor's cite the following governance and management issues as critical to their rating decisions:

- *Governance*: Is the board involved in a meaningful way in strategic decision-making for the hospital? Does the board have the necessary skills to make informed decisions? Do skills of board members complement those of the management team?
- *Management*: Has management proven its ability to weather regulatory change and market threats? Do senior managers inform and educate their board? Do they have demonstrated relevant experience? Do they use effective methods to monitor and improve performance? Do they use systematic strategic and financial planning? Do they assess and serve community needs?[7]

- **Weak markets/access to capital**: Many facilities have deferred capital improvements and require significant upgrades to their physical plants. Yet, access to capital financing is weak for many New York State providers that struggle with high debt burdens and limited liquidity. Without adequate access to capital, hospitals and nursing homes cannot invest in the physical plant or equipment that will ensure high-quality health care.

- **Difficulty attracting and retaining staff:** Hospitals and nursing homes in New York State, as with the rest of the nation, are finding it increasingly difficult to attract and

[6] See: Organzo, A.J., et al, (2006). Are attributes or organizational performance in large health care organizations relevant in primary care practices? *Health Care Management Review. 31 (1)*, 2-10.
Castle, N.G. (2006). Organizational commitment and turnover of nursing home administrators. *Health Care Management Review. 31 (2)*, 156-165.

[7] HFMA, & Pricewaterhouse Coopers (2003). Financing the future report 1: How are hospitals financing the future? Access to capacity in health care today. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/NR/rdonlyres/2E95F3D0-B095-4F04-8AA1-AAE264109806/0/FNF1_No1.pdf

retain quality health care workers. Experienced nurses are in especially short supply. In addition, the migration of young workers from upstate New York to New York City and other parts of the country has exacerbated the shortage of health care workers upstate.[8]

- **Competition from other providers**: Hospitals and nursing homes face increasing competition both within their industries and from alternative providers.
    - **Within the Industry:** Hospitals and nursing homes compete vigorously among themselves in multiple ways. First, hospitals must selectively contract with health plans to be placed on their preferred provider networks. This may induce hospitals to offer significant price reductions to the plan to receive this network designation and/or to provide services attractive to health plans.[9] Second, hospitals are engaged in a "medical arms race" for high-margin services where they make redundant investments in costly clinical technologies to provide services attractive to individual plan beneficiaries and physicians.[10] In the face of declining occupancy rates, nursing homes also compete vigorously with one another to fill beds. Nursing homes are devoting increasing money and effort to marketing activities, targeting discharge planners with their information.
    - **Alternative sites of care:** Hospitals face increasing competition from other providers of care, such as ambulatory surgery centers, that have lower overhead costs than hospitals. The services provided by these niche providers are often well-reimbursed and deprive hospitals of revenues that were historically used to cross subsidize less profitable services. Similarly, nursing homes face increasing competition as more long term services are provided in non-institutional settings. Patient preferences and technology advances are driving a shift to home and community-based settings. This is especially so for nursing homes which provide a great deal of custodial care and who thus compete for the same resident pool with home care agencies and assisted living residences.

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[8] See: Roberts, S. Flight of young adults is causing alarm upstate. (2006, June 13). *New York Times*, p. A1. Available online: http://www.nytimes.com/2006/06/13/nyregion/13census.html

[9] Devers, K.J., Brewster, L.R., & Casalino, L.P. (2003). Changes in hospital competitive strategy: A new medical arms race?. *Health Services Research. 38 (1 Pt 2)*, 447-469. Available online: http://www.pubmedcentral.gov/articlerender.fcgi?tool=pubmed&pubmedid=12650375

[10] Ibid

- **Size of nursing home**: Following national trends, those New York State nursing homes that have closed tend to be smaller institutions. Nationwide, the proportion of homes with fewer than 100 beds declined from 65.7% of total facilities to just over 50%[11] It is important to note that studies have shown that poor quality is less of a contributing factor to closure than size[12].

- **"Cashing out"**: Unlike New York hospitals, a large proportion (48%) of New York nursing homes are proprietary (for-profit), so that the real estate on which a nursing home sits can be sold with few restrictions and the licensed beds are transferable to other nursing homes. Establishing a new nursing home has become increasingly difficult; therefore, each licensed nursing home bed has a high market value. Consequently, some providers prefer to "cash out" rather than to continue operations, often by selling their real estate assets.

Table 3. Nursing Home Sponsorship

Region	Ownership Class		
	Proprietary	Public	Voluntary
Central	36%	8%	56%
Hudson Valley	46%	10%	45%
Long Island	76%	4%	21%
New York City	53%	4%	43%
Northern	32%	19%	49%
Western	45%	12%	43%
Statewide	48%	8%	44%

Source: New York State Department of Health

[11] Centers for Disease Control and Prevention, (1995, 1997, 1999). National Nursing Home Survey. Retrieved July 24, 2006, from National Center for Health Statistics Web site: http://www.cdc.gov/nchs/nnhs.htm#Public-Use%20Data%20Files

[12] Castle, N.G. (2005).Nursing home closures and quality of care. *Medical Care Research and Review. 62 (1)*, 111-132. Available online: http://mcr.sagepub.com/cgi/reprint/62/1/111.pdf

II. Instability of the System

The Commission finds New York States' health care providers to be in critically unstable condition. Providers cannot sustain chronic financial losses and continue to provide the world class health care and important public goods that New Yorkers expect and deserve. "[N]o ordinary enterprise can continue to operate indefinitely with losses. Hospitals with losses for several years should either close, merge, or make changes to become more profitable."[13] As hospitals and nursing homes struggle to remain solvent, they face possible closure due to market forces alone. Because such market driven closures can occur irrespective of or even contrary to public policy goals, access to and quality of care are at risk. The most important institutions to preserve may also be the most fragile.

Hospital System Fiscal Instability

The dire financial situation of New York's hospitals can be seen across all categories of hospitals, from rural to inner-city, from large academic medical centers to small critical access hospitals. According to the Healthcare Association of New York State (HANYS), hospitals in New York State have lost an aggregate $2.4 billion over the past eight years.[14] In 2005 alone, the statewide operating margin[15], which is the traditional measure of hospitals' financial health, was -0.2% (-$95.4 million).[16] While some hospitals are on relatively solid financial ground, the majority are losing money, just breaking even, or operating with a 0-1% financial margin.[17] [18]

Margins in New York have never been generous. Year after year, New York hospitals' operating margins fall far below national norms. Before 1997, those margins were artificially

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[13] Duffy, S.O., & Friedman, B. (1993). Hospitals with chronic financial losses: What came next?. *Health Affairs. 12 (2)*, 151-163. Available online: http://content.healthaffairs.org/cgi/reprint/12/2/151

[14] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[15] Gain or loss from operating sources (operating income/total operating revenue).

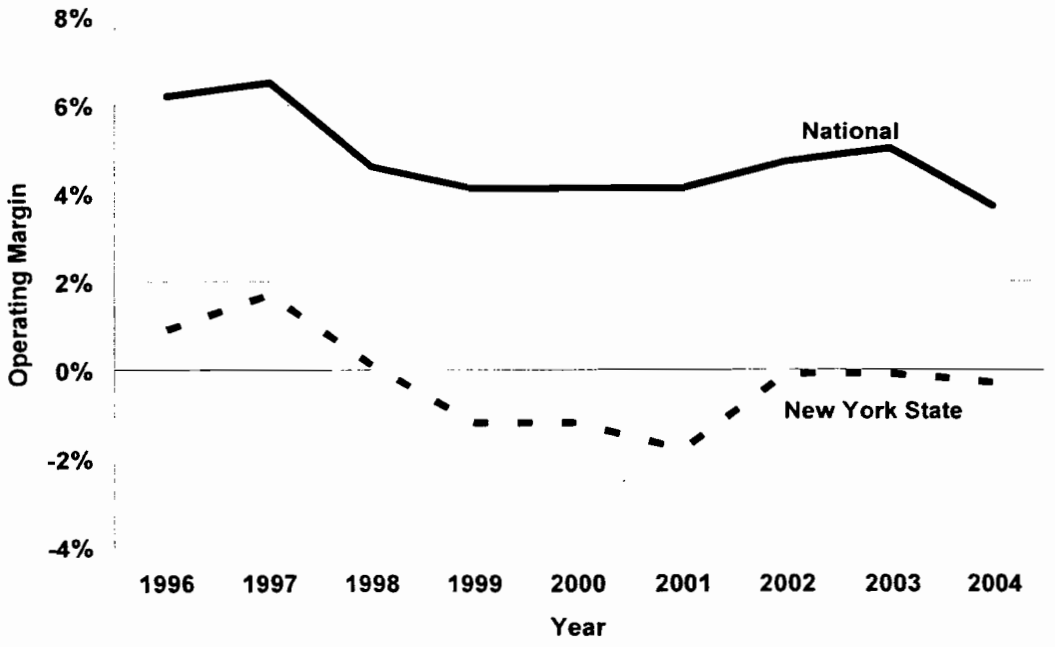
[16] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[17] Ibid

[18] The New York Health Plan Association (NYHPA) paints a different picture by using net income, finding that two-thirds in fact generated profits in 2004, and of the one-third of hospitals that had losses, 15 facilities comprised approximately 75% of total losses for New York State. See: http://www.empirenewswire.com/release/downloads/nyshpa.pdf

maintained in the zero to 1% range, and after a nominal improvement in 1997, they declined precipitously. In 2005, the national average operating margin for hospitals was 3.7%, four percentage points higher than New York State's.[19] Comparing 1996-2003 operating margins in the 50 states and the District of Columbia, New York State has the dubious distinction of ranking among the very worst in terms of operating margins.[20]

Figure 1: Hospital Operating Margins, New York State and United States, 1996-2004



Source: Greater New York Health Association analysis of Medicare cost reports

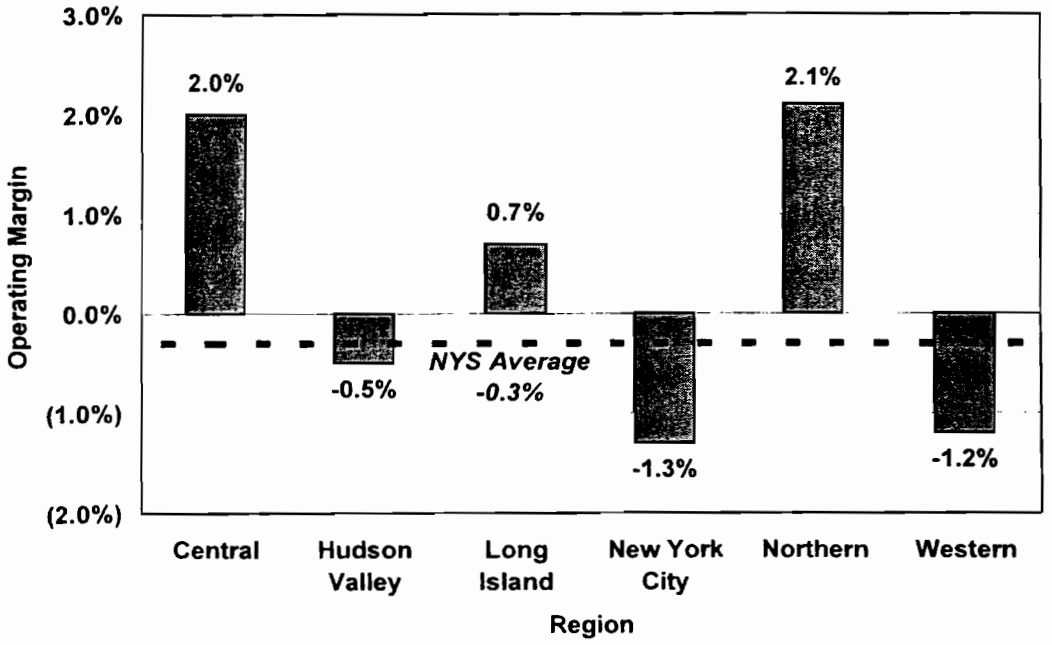
Certain regions in the State fare worse than others. Hospitals in the New York City region are the most financially vulnerable in the State. A July 2003 United Hospital Fund

[19] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[20] Raske, K.E. (2006, February 7). Testimony Of Kenneth E. Raske, President of Greater New York Hospital Association on the Executive Budget Proposal for 2006–07 Before the New York State Senate Finance and Assembly Ways and Means Committees. Retrieved July 21, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/testimony/2006/pt20060207.pdf

found that one-third of New York City hospitals' viability was "in doubt," and faced financial problems "severe enough to jeopardize their continuing viability."[21]

Figure 2: Hospital Operating Margins by Region, 2004



Source: HANYS 2004 Audited Financial Statements[22]

Weak operating margins are not the sole indicators of hospitals' annual financial stress. New York State hospitals are also the most heavily indebted in the nation. The equity financing ratio (the percent of assets financed through cash savings as opposed to debt) in New York is the worst of the 50 states and the District of Columbia. While most hospitals in the nation finance capital investments by an approximately 50%-50% combination of savings and borrowings, New York State had an 18% equity financing contribution rate by 2003.[23] In other

[21] Brooks, P. (2003, July). Losses continue at NYC hospitals; Viability of one-third in doubt. *Hospital Watch, 14 (3)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hwv14n3.pdf

[22] Healthcare Association of New York State. (2005, November 16). Hospitals in New York lose money for seventh year in a row. Retrieved September 21, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/111505_pr.cfm

[23] Raske, K.E. (2006, February 7). Testimony Of Kenneth E. Raske, President of Greater New York Hospital Association on the Executive Budget Proposal for 2006–07 Before the New York State Senate Finance and Assembly Ways and Means Committees. Retrieved July 21, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/testimony/2006/pt20060207.pdf

words, New York State relies more on debt to cover necessary expenses than does any other state's health care delivery system. This heavy dependence on debt will further destabilize New York's health care delivery system, and may cripple the State's health care structure in the long term.

The fiscal problems of NY's hospitals are reflected in and exacerbated by their difficulties raising capital. US hospitals generally have a wide range of capital sources to tap, both external and internal.[24] External sources of capital include proceeds generated from bond issuances, bank loans, sale of real estate, real estate investment trusts, public grants, and philanthropy. Internal sources include operating and non-operating cash flow and divested assets.

The Healthcare Financial Management Association identified two types of hospitals to discern which hospitals have the best access to capital. The first type, those with "broad access" to capital, has stellar financial profiles: high profitability, high liquidity, and limited debt burden. Those with "limited access" to capital are neither profitable nor have adequate liquid assets, and are significantly burdened with debt. According to this report, New York's access to capital is bleak. Compared to the fifty states and DC, "New York ranks first in both proportion and number of hospitals designated as having limited access to capital."[25]
The State's limited access to capital is also reflected in the bond ratings of the various New York hospitals. Due to many factors, including average age of plant, days cash on hand, as well as operating margin and debt to capitalization ratios, the hospitals' bond ratings are dismal. In its February 2006 report, the Moody's rating agency referred to New York State as "one of the most difficult, if not the most difficult, states to operate a hospital."[26]

[24] Healthcare Financial Management Association, & Pricewaterhouse Coopers. (2003). Financing the future project reports I and II. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/library/accounting/capitalfinance/FinancingtheFuture.htm

[25] Ibid

[26] Moody's Investor's Service Global Credit Research. (2006). Not-for-profit hospitals: 2006 State of the States. Moody's Investor's Service 2006 Outlook.

Table 4. Statewide Ranking of Hospitals with Limited Access to Capital

Rank	Wide	Constrained
1	Indiana	**New York**
2	Wisconsin	Hawaii
3	Nebraska	Washington, DC
4	New Hampshire	Pennsylvania
5	Vermont	West Virginia
6	Minnesota	New Jersey
7	Ohio	North Dakota
8	Virginia	Massachusetts
9	Arizona	California
10	Tennessee	Connecticut

Source: Solucient[27]

The low credit rating of the hospitals has two primary effects. First, the higher the debt service costs due to poor credit ratings, the less an institution can spend on other expenditures such as capital improvement, technology upgrades, and pension coverage. Second, because the bond ratings are bleak, the vast majority of not-for-profit hospitals and nursing homes in the DASNY portfolio require some sort of credit enhancement. Credit enhancement sources include letters of credit, bond insurance, local taxes, and the Federal Housing Administration's (FHA) section 242 Hospital Mortgage Insurance Program.[28] Notably, in 2000, the FHA program insured over 70% of hospital credits issued through DASNY, and over 60% of FHA-insured debt nationwide is in New York State.[29]

[27] Healthcare Financial Management Association, & Pricewaterhouse Coopers. (2003). Financing the future II Report 6: The outlook for capital access and spending. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/NR/rdonlyres/ED7D0E8B-E896-4B1C-8466-B33CA4B72095/0/FF2_No6_Outlook_w1.pdf

[28] See: United States Government Accountability Office. (2006). *Hospital mortgage insurance program: Program and risk management could be enhanced* (1-66), showing that the geographic concentration of FHA-insured hospitals located in New York "makes the [FHA] program vulnerable to state policies and regional economic conditions." Availabe online: http://www.gao.gov/new.items/d06316.pdf

[29] Health Care Reform Working Group. (2004). *Health Care Reform Working Group – Final Report, November 17, 2004*, 1-32. Available online: http://www.health.state.ny.us/health_care/medicaid/related/health_care_reform/pdf/final_report.pdf

Table 5. New York State Hospital Medians Compared to Rating Agency Medians

	Hospital Medians								
		S&P, All Health Care, 2004**				Fitch Nonprofit Hospital and Health Care System, 2004***			
Ratios	New York State, 2003*	AA+ to AA-	A+ to A-	BBB+ to BBB-	Spec	AA	A	BBB	Below BBB
Average Age of Plant	12.5	8.9	9.1	9.8	12.6	9.4	9.9	9.3	13.1
Days Operating Cash Available	30.1	211	159	110	50	232.2	177.2	117.5	49.3
Operating Margin	0.0%	3.1%	3.5%	1.2%	(1.3%)	3.5%	2.5%	1.0%	(1.8%)
Debt to Capitalization	50.9%	32.8%	37.3%	44.3%	65.3%	34.8%	39.0%	47.3%	75.1%

Source: * DASNY, 2003 audited financial statements
** Standard and Poor's, "U.S. Not-For-Profit Health Care 2004 Median Ratios," June 10, 2004
*** FitchRatings, Health Care Special Report, "2005 Median Ratios for Nonprofit Hospitals and Health Care Systems," August 9, 2005

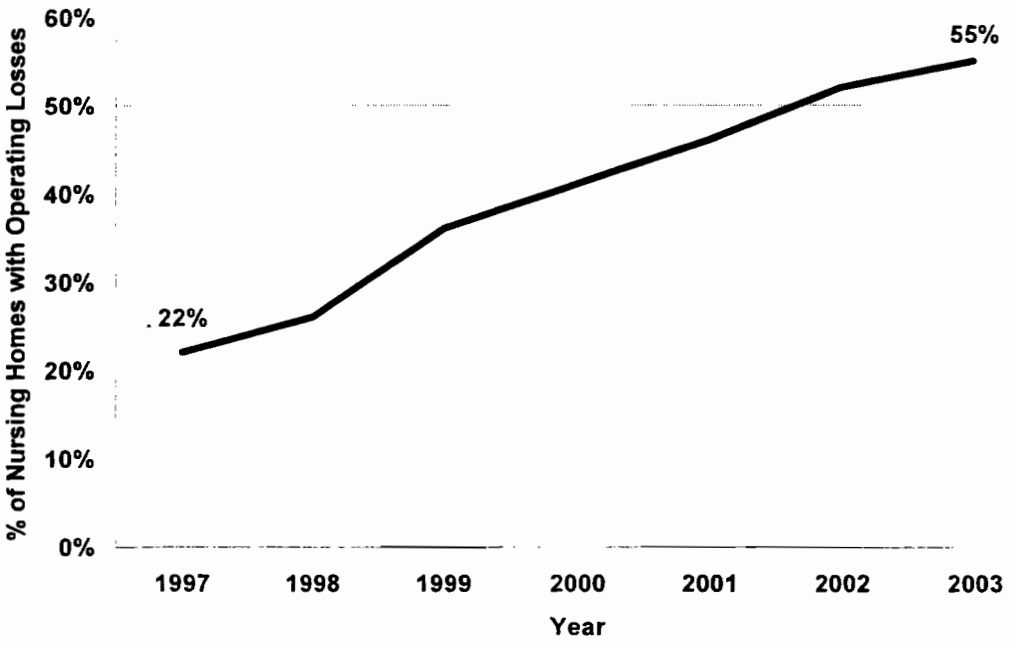
To help ameliorate the hospitals' limited capital access, DASNY, the State agency that provides financing and construction services to not-for-profit healthcare facilities and the State's largest issuer of health-related debt, issued secured hospital revenue bonds. These bonds "were issued to allow financially distressed New York not-for-profit- hospitals access to the capital markets. The establishment of the Secured Hospital Program became necessary because the physical plants of certain hospitals were deteriorating, but such hospitals' financial conditions were too weak to enable them to borrow the monies necessary to modernize their facilities."[30] Authorization to issue bonds under this program, however, expired on March 1, 1998. Approximately $837 million is outstanding, spread over ten institutions. Currently, DASNY offers multiple programs to provide financing for capital construction and rehabilitation projects for non-profit health care facilities in New York State which are secured by various credit structures.

[30] Dormitory Authority State of New York. Financial services: Health care. Retrieved July 24, 2006, from Dormitory Authority State of New York Web site: http://dasny.org/finance/finserv/index.php#anchor820988

Nursing Home System Fiscal Instability

New York State's nursing homes are in a similarly precarious situation. In 1997, less than a quarter of the State's nursing homes were operating in the red. The majority - at least 55% - now operate at a loss.

Figure 3: Nursing Homes with Operating Losses, 1997-2003



Source: Residential Health Care Facility-4 (RHCF-4) Cost Reports, 1997-2003

The financial strain on NY nursing homes may be increasing. According to a survey conducted by the Joint Association Task Force on Nursing Home Reimbursement, New York's median nursing home margin fell from +0.6% in 2001 to -0.1% in 2002, and again to -0.6% in 2003. Rural nursing homes are in much worse financial health, with median margins declining from -5.2% to -7.4% in the same time period.[31] As a result of these poor margins, nursing

[31] Joint Association Task Force on Nursing Home Reimbursement. (2006). *Joint Association Task Force on Nursing Home Reimbursement: A briefing for member facilities.* 6-7.
The Task Force was comprised of the New York Association of Homes and Services for the Aging, the Healthcare Association of New York State, and the New York State Health Facilities Association.

homes financial position is also deteriorating: the median number of days cash-on-hand in 2003 was only 21.[32]

Pressures on the System

Numerous pressures on the system contribute to the weak bottom lines of NY's health care providers. Moody's Investor Services attributes the bleak financial condition of New York hospitals to: the state's "challenging" demographics, including a high Medicaid-dependent and large immigrant population; payer concentration (tightening of the insurance market); a high degree of competition between providers; high cost of operation; merger difficulties; large number of high-cost academic medical centers; and the legacy of a highly regulated system.[33] Additional major factors include:

- **Uninsured residents.** The problem of the uninsured and underinsured is one of the most vexing problems facing health care delivery in both New York State and the United States as a whole. Over 45 million Americans below 65 years-old, 18% of the non-elderly US population, lacked health care coverage in 2004.[34] An estimated 17% of New York State residents under age 65, almost 3 million New Yorkers, are uninsured.[35] A large portion of the State's uninsured population lives in New York City; 25% of City residents are uninsured, whereas 13% of State residents living outside of the City are uninsured.[36] Most of the uninsured in New York are low-income, working adults. Members of racial/ethnic minorities are disproportionately uninsured.

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[32] Department of Health. (2003). *Residential Health Care Facility Cost Reports (RHCF-4)*.

[33] Moody's Investor's Service Global Credit Research. (2006). Not-for-profit hospitals: 2006 State of the States. Moody's Investor's Service 2006 Outlook.

[34] Kaiser Commission on Medicaid and the Uninsured, (2006, January). The uninsured: a primer - Key facts about Americans without health insurance. Retrieved July 24, 2006, from Kaiser Family Foundation Web site http://kff.org/uninsured/upload/7451.pdf

[35] Kaiser Family Foundation, New York: Health insurance coverage of nonelderly 0-64, states (2003-2004), U.S. (2004). Retrieved July 24, 2006, from statehealthfacts.org Web site: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=New+York&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Nonelderly+%280%2d64%29

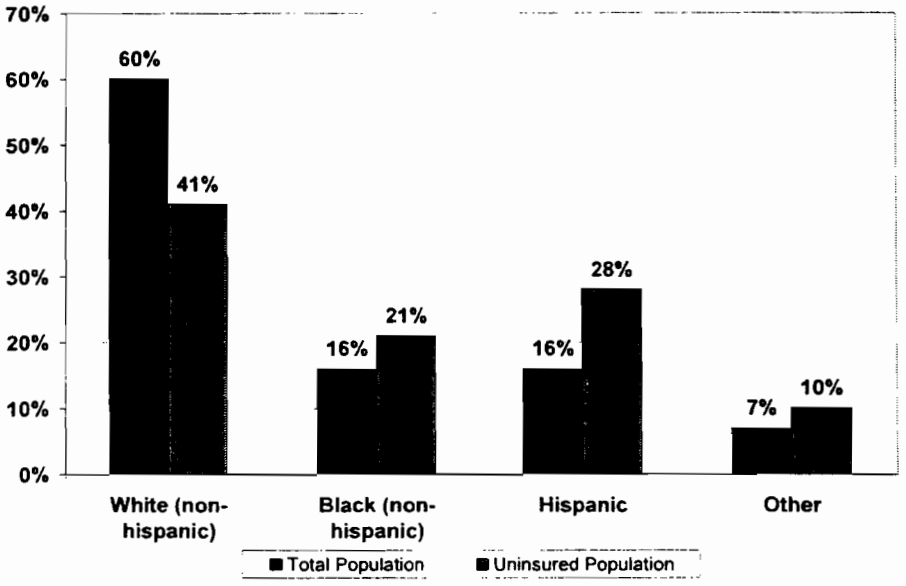
[36] Holahan, D., Ely, A., Haslanger, K., Birnbaum, M., & Hubert, E. (2004). Health insurance coverage in New York, 2002. Retrieved July 24, 2006 from United Health Fund Web site: http://www.uhfnyc.org/usr_doc/chartbook2004.pdf

Table 6. Uninsured in New York City and New York State, Nonelderly, 2002-2003

	Uninsured Nonelderly (Children and Adults under age 65)	
	New York City	New York State
At or below 200% of the Federal Poverty Level	65%	62%
Workers and their dependents	75%	78%
Adults ages 18-64	83%	83%

Source: March 2003 and March 2004 Current Population Survey, Annual Social and Economic Supplement

Figure 4. Distribution of Uninsured by Race/Ethnicity for New York State, Nonelderly, 2002-2003



Source: March 2003 and March 2004 Current Population Survey, Annual Social and Economic Supplement

Lack of health coverage is a serious burden for the uninsured themselves and for the institutions that care for them. Those without health coverage are less likely to seek and receive preventive care, more likely to be hospitalized for avoidable health problems, and more likely to be diagnosed in the later (and more expensive) stages of disease.[37] Even in New York

[37] Kaiser Commission on Medicaid and the Uninsured, (2006, January). The uninsured: a primer - Key facts about Americans without health insurance. Retrieved July 24, 2006, from Kaiser Family Foundation Web site http://kff.org/uninsured/upload/7451.pdf

City with its vast public hospital system, uninsured residents face larger obstacles to care than those with insurance.[38]

NY's hospitals provide substantial amounts of uncompensated care to the uninsured and also receive some support for their care of the uninsured. New York is one of a few states that has a public funding pool to reimburse hospitals for free care they provide as well as for bad debt from patient care.[39] In FY 2005-06, New York State provided $847 million per year in HCRA funding to subsidize care for the uninsured; $765 million from the general hospital indigent care pool, and $82 million from the high need indigent care pool. Pool funds are distributed through a complex formula based in part on the level of unreimbursed care each hospital provides in comparison to other hospitals and the proportion of unreimbursed care to each hospital's total costs.[40] The distribution formula relies on 1996 cost data and has not been updated.. The pool does not completely compensate hospitals for the cost of providing care to uninsured New Yorkers. According to GNYHA, HCRA covers a statewide average of 50% of the cost of providing care to the uninsured, ranging from 20% to 80% coverage for particular hospitals.[41] In addition to HCRA, hospitals rely on other public monies to support their margins.

- **Outmigration of services.** The delivery of many acute care services has shifted from an inpatient to an outpatient setting. This shift has been driven by changing reimbursement incentives, clinical technology and pharmaceutical innovation, and consumer preferences. Cardiac catheterization, colonoscopy, and cancer treatment (radiation therapy and chemotherapy) services are now largely provided on an ambulatory basis.

This shift in care has precipitated the growth in ambulatory surgery centers (ASCs), outpatient cancer centers, and outpatient diagnostic centers. These centers increase competition in health care, and may improve quality by specialization of services.[42] However, many outpatient centers practice "cream skimming," choosing to provide the most profitable

[38] Louis Harris and Associates, Inc. (1998, February). 1997 survey of health care in New York City. Retrieved July 24, 2006, from The Commonwealth Fund Web site: http://www.cmwf.org/surveys/surveys_show.htm?doc_id=228066

[39] More information is available online: http://www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

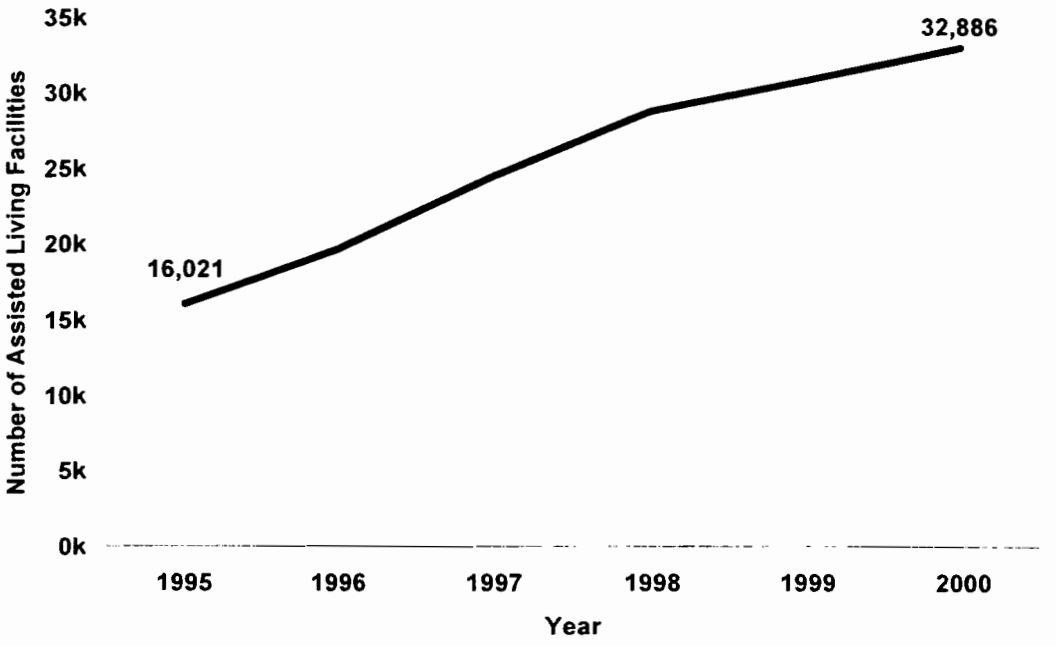
[40] Greater New York Hospital Association. Questions and answers on the New York health care reform act. Retrieved July 24, 2006, from the Greater New York Hospital Association Web site: http://www.gnyha.org/pubinfo/HCRA_QA.pdf

[41] Greater New York Hospital Association. Questions and answers on the New York health care reform act. Retrieved July 24, 2006, from the Greater New York Hospital Association Web site: http://www.gnyha.org/pubinfo/HCRA_QA.pdf

[42] Shactman, D. (2005). Specialty hospitals, ambulatory surgery centers, and general hospitals: Charting a wise public policy course. *Health Affairs. 24 (3)*, 868-873. Available online: http://content.healthaffairs.org/cgi/content/full/24/3/868?

medical services without bearing the burden of providing other less attractively reimbursed ones. They also do not bear the full overhead costs incurred by institutions in which the services were previously provided. Because these centers capture some of the lucrative services from hospitals by selecting certain profitable diagnostic related groups (DRGs), general hospitals may lose those profitable patients to the centers and will continue to disrupt the general hospitals' cross-subsidization of unprofitable services that only Article 28 hospitals are required to provide. Second, the outpatient centers may avoid patients who are uninsured or underinsured, leaving the burden of uncompensated care solely on general hospitals.[43] Finally, the shift of the locus of care could further reduce New York hospitals' low occupancy rates and exacerbate the problem of excess capacity.[44]

Figure 5: Estimated Number of Assisted Living Facilities in the United States, 1995-2000



Source: National Center for Assisted Living

[43] See, e.g., Guterman, S. (2006). Specialty hospitals: A problem or a symptom? *Health Affairs. 25 (1)*, 95-105. Available online: http://content.healthaffairs.org/cgi/content/full/25/1/95

[44] Shactman, D. (2005). Specialty hospitals, ambulatory surgery centers, and general hospitals: Charting a wise public policy course. *Health Affairs. 24 (3)*, 868-873. Available online: http://content.healthaffairs.org/cgi/content/full/24/3/868?

Within the long term care sector, nursing facilities in New York State are also facing some competition from home and community-based providers. The growth of attractive, supportive housing alternatives for seniors with the means to afford them helped drive these changes in nursing home occupancy rates and patient populations. These newer alternatives include a variety of residential senior housing and assisted living arrangements. In 2002, it was estimated that assisted living facilities in the United States housed 910,000 people.[45]

Assisted living has grown rapidly as a supportive housing arrangement. However, because costs are high and public reimbursement scarce, older persons with modest means have had limited access to this option. This may be changing. While efforts are in their nascent stages, the AARP reports that there have been successful experiments in extending assisted living services to low income, frail elderly residents of subsidized housing.[46] Many states have advanced the growth of residential care through assisted living by providing for such facility care in their Medicaid Waiver programs. As a result, some states have seen an increase in ALP residents and a concomitant decrease in nursing home clients.

Table 7. Number of Medicaid Waiver Clients in Residential Settings

State	Year		
	2000	2002	2004
Arizona	1,240	2,300	3,067
Colorado	2,654	3,773	3,804
Florida	1,458	2,681	4,167
Georgia	2,262	2,759	2,851
Minnesota	397	2,895	4,144
New Jersey	699	1,500	2,195
Oregon	2,573	3,600	3,731
Washington	2,919	3,762	7,404

Source: AARP, Wilden, R. & Redfoot, D.L., "In Brief: Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons With Low Incomes," Research Report of the AARP Public Policy Institute, January 2002.

[45] Mollica, R. (2002). State assisted living policy: 2002. Retrieved July 24, 2006, from National Academy for State Health Policy Web site: http://www.nashp.org/_docdisp_page.cfm?LID=24F0A0A1-2066-4E84-B113F4B919FC006C

[46] Wilden, R., & Redfoot, D.L. (2002, January). Adding assisted living services to subsidized housing: Serving frail older persons with low incomes. Retrieved July 24, 2006, from AARP Web site: http://assets.aarp.org/rgcenter/il/2002_01_living.pdf

In addition to assisted living, growth has also occurred in home and community-based alternatives to institutional care. There are now more than 3,500 adult day centers operating in the US providing care for 150,000 seniors each day.[47]

The Program of All-Inclusive Care for the Elderly (PACE) model successfully shifts the focus of long-term care to non-institutional settings. PACE combines Medicare and Medicaid payments into one capitated payment (set fee per patient) to long-term care providers, who carefully plan and manage service delivery to keep nursing-home-eligible seniors out of hospitals and nursing homes. Program evaluations have shown a decrease in hospital and nursing home utilization among PACE participants, which is more powerful due to the fact that all participants have chronic conditions and disabilities. PACE expansion in New York has been slow, but there are some successful growing programs and the legislature recently approved the addition of four more "pre-PACE-like" (Medicaid capitation only) programs.

o **Declining Hospital Average Length of Stay (ALOS).** Declines in ALOS exacerbate problems associated with excess inpatient capacity. While still higher than the national average, New York State's inpatient hospital ALOS has fallen considerably. The ALOS for New York State in 2004 was 6.1 days, down from 8.4 days in 1994. Prior to 1994, ALOS was consistently in the range of 8.5 to 9.3 days).[48] The national average LOS for hospital inpatient stays was 4.8 days in 2003, down from 5.7 days in 1994.[49] The recent drop in LOS is primarily attributable to clinical and pharmaceutical innovations and an increase in ambulatory or same-day surgery. Treatment advances, including new drug therapies and less invasive surgical techniques, have made possible fewer and shorter hospital stays, as have cost-management controls and alternative forms of health care organization and payment.[50]

Though lower than in the past, the high ALOS in NY hospitals is not justified by patient severity and should be further reduced. A shorter length of stay can often benefit

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[47] (2006, July 14). Aging services in America: The facts. Retrieved July 24, 2006, from American Association of Homes and Services for the Aging Web site: http://www.aahsa.org./aging_services/default.asp

[48] Department of Health. (2004). *Statewide Planning and Research Cooperative System,* 243. Available online: http://www.nyhealthcarecommission.org/docs/sparcs_complete_november2005.pdf. Earlier information is available in the Statewide Planning and Research Cooperative System Annual Reports.

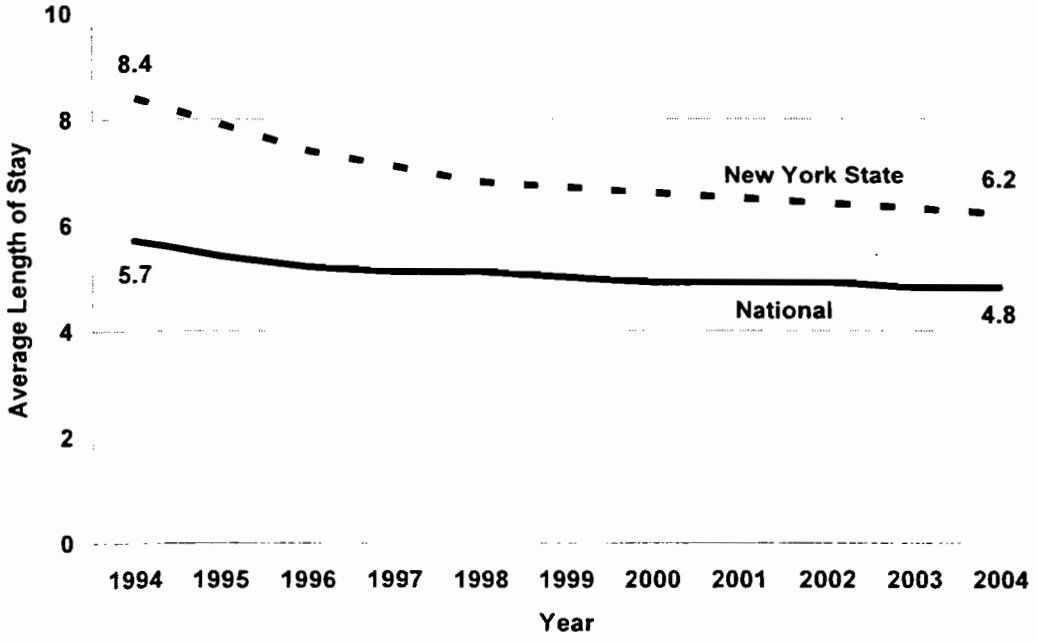
[49] Kozak, L.J., Owings, M.F., & Hall, M.J. (2004). National hospital discharge survey: 2001 annual summary with detailed diagnosis and procedure data. *Vital Health Statistics. 13 (156).* Available online: http://www.cdc.gov/nchs/data/series/sr_13/sr13_156.pdf

[50] (2002, October 10). Length of hospital stays continues to decline. Retrieved July 24, 2006, from HealthLink: Medical College of Wisconsin Web site: http://healthlink.mcw.edu/article/1013703780.html

patients, allowing them to return to their daily lives soon after hospitalization. Patients can be exposed to infections often present in hospitals and to the possibility of medical errors. The benefits of getting people up and moving around are best realized by moving them to residential environments such as their homes or nursing homes.[51] If ALOS were reduced to more appropriate levels, the excess capacity in New York State would be substantially greater than it is today.

In addition, shorter ALOS can have significant cost benefits for hospitals. Most payers have abandoned per diem payment structures to correct the perverse incentive to extend a hospital's ALOS as long as possible. The shift to a prospective payment system (PPS) means that hospitals receive a fixed payment per admission and a longer length of stay does not generate extra revenue. Instead, the costs associated with a longer LOS increase costs and cut into a hospital's margins.

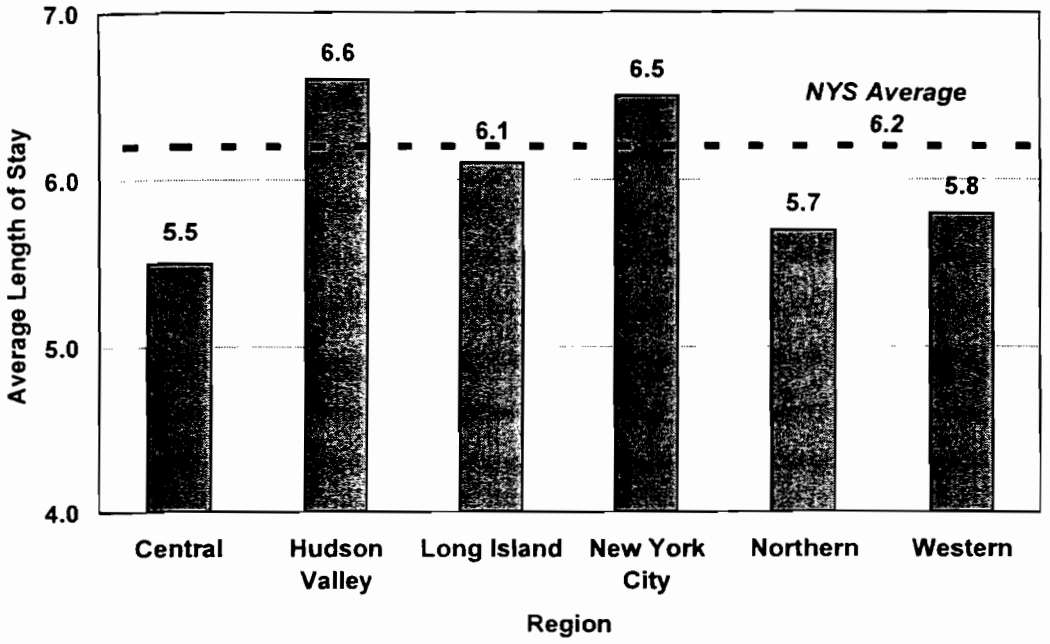
Figure 6: New York State and National Hospital Length of Stay, 1994-2004



Source: National Hospital Discharge Survey: National Center for Health Statistics and Statewide Planning and Research Cooperative System (SPARCS) data

[51] Excellus Blue Cross/Blue Shield. (2002). Average length of stay in upstate New York hospitals: Opportunities for savings. *Excellus Health Policy Reports. 4*, 1-16. Available online: https://www.excellusbcbs.com/download/files/excellus_health_policy_report_4.pdf

Figure 7: New York State Hospital Length of Stay by Region, 2004



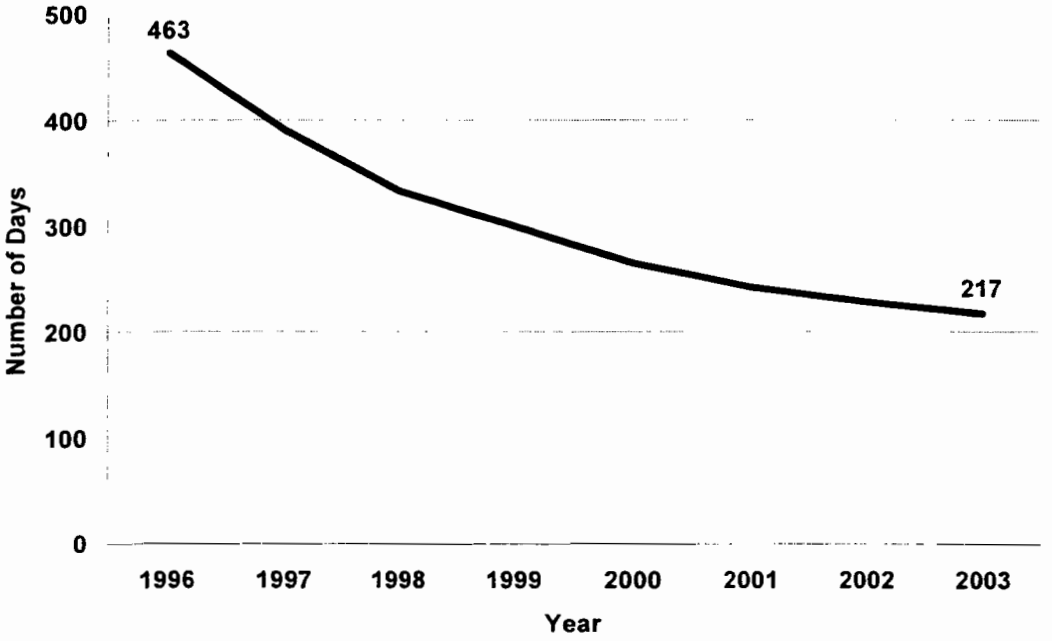
Source: 2004 Statewide Planning and Research Cooperative System (SPARCS) data

As with hospitals, ALOS in New York's nursing homes has declined dramatically over the last decade. Much of the decrease is attributable to changes in the service mix of nursing homes; many facilities have reduced their focus on traditional long-term services to expand their post-acute short-term rehabilitation services, which generally have a length-of-stay of less than 30 days. Between the growing short-stay services and the changing admission patterns for longer stay residents, the average length of stay in New York's nursing homes has been cut in half in just under seven years. The statewide average was 217 days in 2003, down from 463 days in 1996.

This increased churning of nursing home residents has had an impact on facility operations and finances. Facilities must provide increased nursing ratios, increased housekeeping services, increased documentation and supervision, and specialized clinical and therapeutic services. While Medicare pays additionally for each resident requiring more nursing and therapy, Medicaid reimbursement had been capped according to the facility's 1983 cost structure and other ceilings. Therefore, while the industry's costs have risen dramatically,

it is not clear that revenues have kept pace. Recent legislation to update the nursing home base year may address this imbalance.

Figure 8: New York State Nursing Homes Average Length of Stay, 1996-2003



Source: Residential Health Care Facility-4 (RHCF-4) Cost Reports, 1996-2003

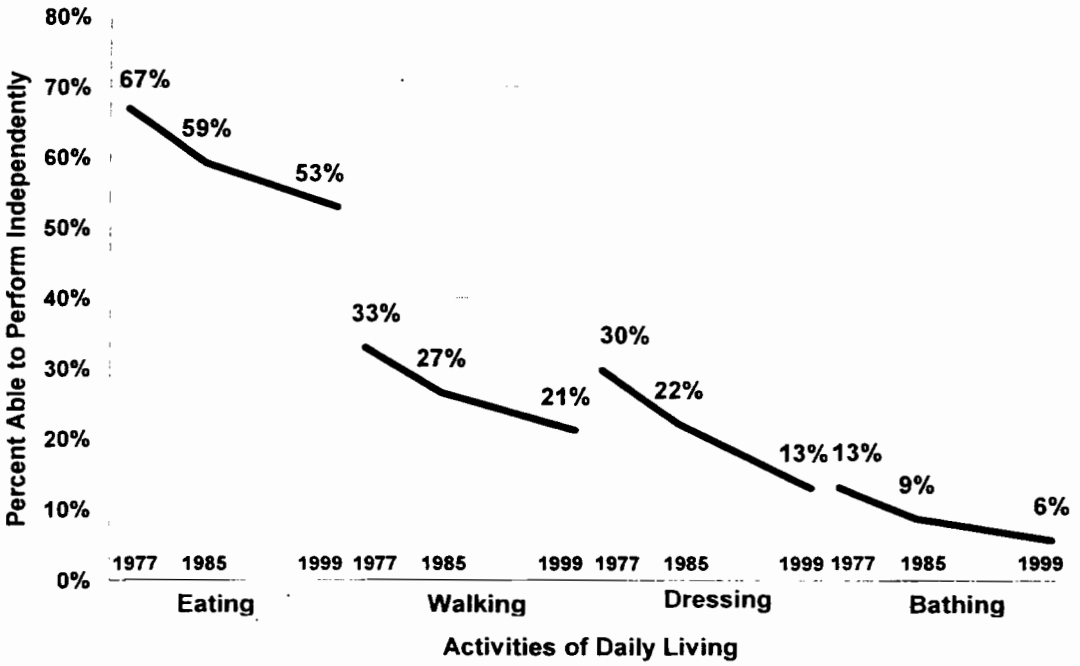
o **Drop in Severity of Illness (Hospitals).** Contrary to the national trend, the severity of illness of New York City residents who require hospitalization as measured by the case mix index (CMI) has declined sharply in a majority of City hospitals.[52] Due largely to fortunate developments related to major epidemics (e.g., AIDS, substance abuse, tuberculosis), high-acuity admissions have fallen. This drop in CMI directly affects the financial viability of the State's and City's hospital system. "Under DRG payment systems, the CMI determines how much inpatient revenue a hospital will receive. In theory, since DRG payments are based on costs, the CMI should not affect hospital profitability. However, in practice, the CMI is often related to profits."[53]

[52] United Hospital Fund, (2005).Drop in severity of illness further strains hospital finances. *Hospital Watch. 16 (1)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hw16_1.pdf

[53] United Hospital Fund, (2005).Drop in severity of illness further strains hospital finances. *Hospital Watch. 16 (1)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hw16_1.pdf

o **Increase in Severity of Illness and Disability (Nursing Homes):** While the hospitals may be experiencing severity declines, nursing homes are dealing with more needy patients and residents—getting them "sicker and quicker." Nationwide, nursing home residents are older and more frail, and this is certainly true in New York as well.

Figure 9: Percentage of Nursing Home Residents able to Independently Perform Activities of Daily Living



Source: National Nursing Home Survey

o **Workforce Issues.** New York is more expensive than most states to employ workers, including nurses and other health care workers. According to the Bureau of Labor Statistics, New York ranks sixth among all the States in salaries for registered nurses.[54] Retention of experienced health care personnel, especially nurses, is also a challenge. A 2004 GNYHA study found an 8.5% turnover rate for registered nurses at GNYHA-member hospitals. More than one- third of the hospitals reported turnover rates of 10% or higher.[55] To address these

[54] Bureau of Labor Statistics, (2005). Occupational employment and wages, May 2005: Registered Nurses. Retrieved July 24, 2006, from U.S. Department of Labor Web site: http://www.bls.gov/oes/current/oes291111.htm

[55] Greater New York Hospital Association, (2004, April 23). New York-area hospitals continue to face shortage of nurses. Retrieved July 24, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/press/2004/pr20040423.html

issues, more than $1.3 billion has been invested in workforce recruitment, retraining, and retention though various programs.

Table 8. Employment and Wages of Registered Nurses by State, May 2005

State	Estimated Total Employment	Mean Wage	
		Hourly	Annual
California	226,350	$33.86	$70,430
Maryland	49,010	$32.37	$67,330
Massachusetts	76,870	$31.85	$66,250
Hawaii	9,240	$31.49	$65,490
New Jersey	80,940	$30.32	$63,070
New York	164,370	$30.29	$63,010

Source: Bureau of Labor Statistics, May 2005 Occupation and Wage Estimates

For nursing homes, turnover for registered nurses, licensed practical nurses, and certified nursing aides categories is significant. While better than the national average, turnover rates for these categories are between 40 and 50%. These translate to vacancy rates of 16-17% for RNs and LPNs.

Table 9. Nursing Home Staff Turnover, 2002

Licensure	New York State	National
C.N.A	41.7%	71.1%
L.P.N	33.3%	48.9%
Staff R.N	44.4%	48.9%

Source: American Health Care, 2002 Survey of Nursing Staff Vacancy & Turnover Rates in Nursing Homes

Often, these vacancies are "filled" with overtime and agency staffing, both of which contribute to a facility's instability. Over-time and agency payments are a significant financial burden for many nursing homes, whose Medicaid rates do not recognize these increase costs. Moreover, both overtime use and agency staff use are correlated with lower quality measures, so that a facility's reputation—and often its occupancy—are hurt by staff turnover and vacancies.

o **Shifting Demographics and Consumer Preferences.** Changes in demographics have a significant impact on the demand for hospital and nursing home beds.[56] Trends in total population suggest that statewide need for inpatient capacity will remain flat for the foreseeable future, with some differences at the regional level. Aging of the population will occur slowly, affecting demand only gradually. Growth in the 75+ cohort, which generates the largest demand for nursing home care, will be relatively flat over the next 20 years. The average baby boomer will be 55 in 2010, so the full impact of this generation will not be felt until the 2020s, when the baby boom generation first reaches their mid-70s. Older people today are healthier than older people of decades ago. People live longer, retire later, have fewer disabilities, have less functional loss, and report themselves to be in better health. The National Academy of Sciences reports a statistically significant 3.6% decline in chronic disability prevalence rates in the elderly United States population, from 24.9% in 1982, to 21.3% in 1994. These trends, together with continuing advances in medical care may have contributed to the nursing home utilization decline for the 65+ population between 1998 and 2003.

Beyond demographics, consumer attitudes towards and preferences for health care services are changing. Patients are now more engaged in medical decision-making, participate as active partners in their care, value living independently, and shun institutional care arrangements. Technology advances increasingly allow patients to realize their preferences. The impact of these shifting preferences is likely to be felt most strongly in the long term care continuum of services. While the bulk of today's frail elderly, who were shaped by the Depression and WWII, are fairly trusting and accepting of institutions, the generations behind them—including the "silent generation" and the "baby boomers" show strong preferences for non-institutional alternatives.

[56] Commission on Health Care Facilities in the 21st Century. (2006). *Planning for the future: Capacity needs in a changing health care system*, 1-41. New York: Commission on Health Care Facilities in the 21st Century.

III. Excess Capacity

Excess capacity in our state's health care system locks us into a vicious cycle. The costs associated with maintaining unneeded beds and institutions are steep. Perpetuating inefficiencies at weak, unneeded facilities drives the costs of health care ever higher. As a result, access to care is diminished, quality of care suffers, safety net functions are threatened, and modern health care becomes increasingly unaffordable for individuals, businesses, and government.

New York State Has Too Many Hospital Beds

A fundamental driver of the crisis in New York's health care delivery system is excess capacity. Simply stated, New York State is over-bedded and many beds lie empty. There are approximately 3.3 hospital beds per 1,000 New Yorkers, compared to the national figure of 2.8 beds per 1,000 people.[57] Were ALOS in NY hospitals closer to national norms, the excess capacity in the state would be substantially greater. Even a statewide reduction in ALOS to the levels in the Central and Northern regions of the state would result in significantly more excess capacity.

Table 10. Beds Per 1,000 Population – Selected States

Rank	State	Beds/1,000 Population (2004)	Rank	State	Beds/1,000 Population (2004)
1	District of Columbia	6.2	11	Iowa	3.7
2	South Dakota	6.0	11	Kentucky	3.7
3	North Dakota	5.6	13	Arkansas	3.5
4	Montana	4.7	13	Tennessee	3.5
5	Mississippi	4.5	15	Alabama	3.4
6	Nebraska	4.2	16	Missouri	3.3
7	West Virginia	4.1	**16**	**New York**	**3.3**
8	Wyoming	4.0	18	Minnesota	3.2
9	Kansas	3.8	18	Pennsylvania	3.2
9	Louisiana	3.8	20	Oklahoma	3.1

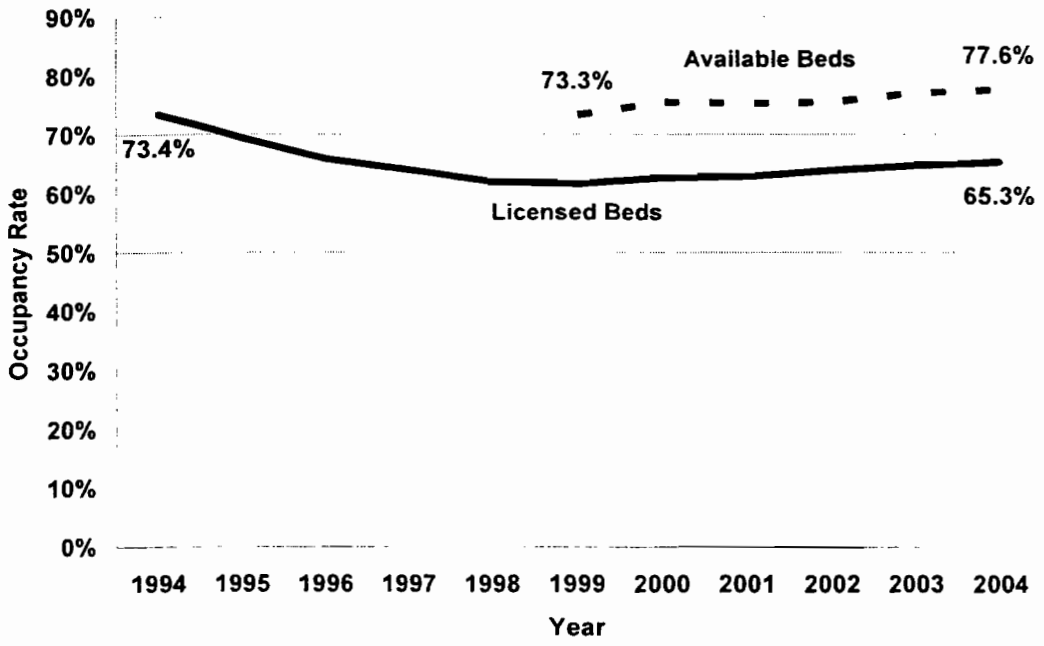
Source: Kaiser Family Foundation

[57] Kaiser Family Foundation, New York: Beds per 1,000 Population, 1999-2004. Retrieved August 21, 2006, from statehealthfacts.org Web site: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=New+York&category=Providers+%26+Service+Use&subcategory=Hospital+Trends&topic=Beds%2c+1999%2d2004

Excess capacity is both a cause and an effect of low and steadily declining hospital occupancy rates. The statewide hospital occupancy rate has fallen from 82.8% in 1983 to 65.3% in 2004, a decrease of 17.5%, including a decline from 73.4% of certified beds in 1994, a decrease of 8.1%. On a given day, as many as one-third or more of the state's hospital beds lie empty. This is far lower than what historically has been considered an ideal rate of 85%, which ensures efficient operations and allows some surge capacity for periods when the daily patient census increases. On a staffed bed basis, approximately 77% of beds statewide are occupied.[58]

While statewide occupancy rates are low, there is some variation of occupancy both between and within regions. The average occupancy rate for many individual hospitals show them to be more than half empty, and some regions of the State, including the Western and Central regions, have especially low occupancy rates based on both certified and staffed bed count.

Figure 10. Hospital Licensed and Available Bed Occupancy Rates, 1994 to 2004



Source: 2004 Statewide Planning and Research Cooperative System (SPARCS) data

[58] New York State Department of Health. (2004). *Institutional Cost Reports*, 1-52. Available online: http://www.nyhealthcarecommission.org/docs/2004_icr_commission_data.pdf

Figure 11. Hospital Licensed Bed Occupancy Rates by Region, 2004

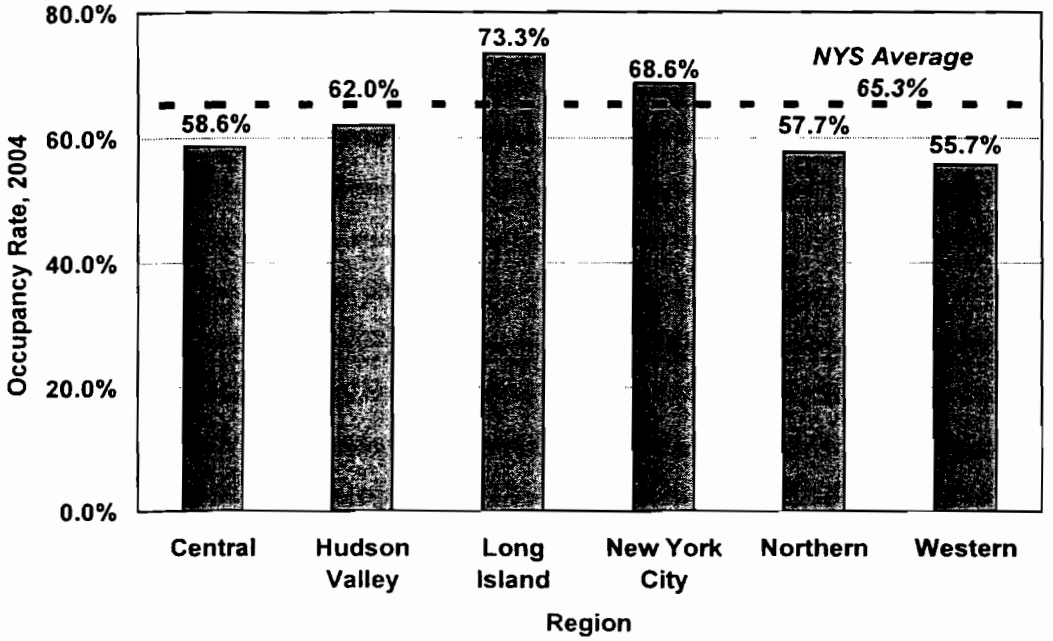
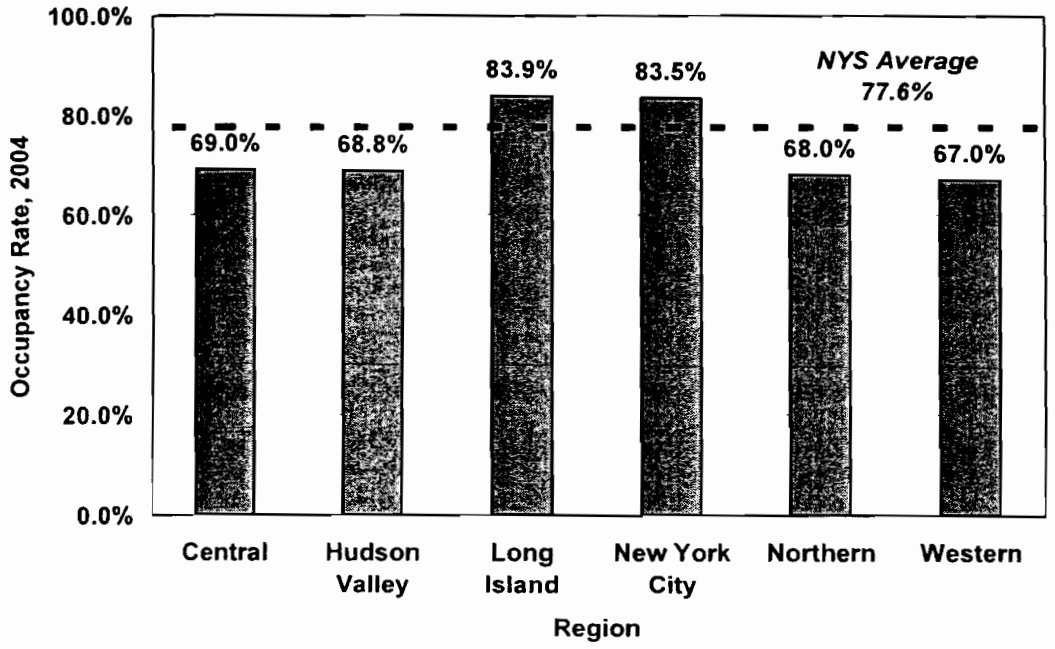


Figure 12. Hospital Available Bed Occupancy Rates by Region, 2004



Regions of New York State Have Too Many Nursing Home Beds

Nursing home occupancy in New York State has been steadily declining, from 97% in 1997 to 93% in 2004. There are various definitions of the ideal nursing home occupancy rate. A 97% occupancy rate historically has been the goal for nursing homes in terms of viability and efficiency. The New York State Department of Health also uses 97% as a measure of whether new beds can be made available in region. From a financial perspective, maintaining at least a 95% occupancy rate is crucially important to nursing homes because that is the rate required to qualify for "bed-hold payments," which allows the State to compensate nursing homes in order for the nursing home to reserve an empty bed while waiting for its resident to return from a hospitalization.

Figure 13. Nursing Home Licensed Bed Occupancy Rates, 1994 to 2004

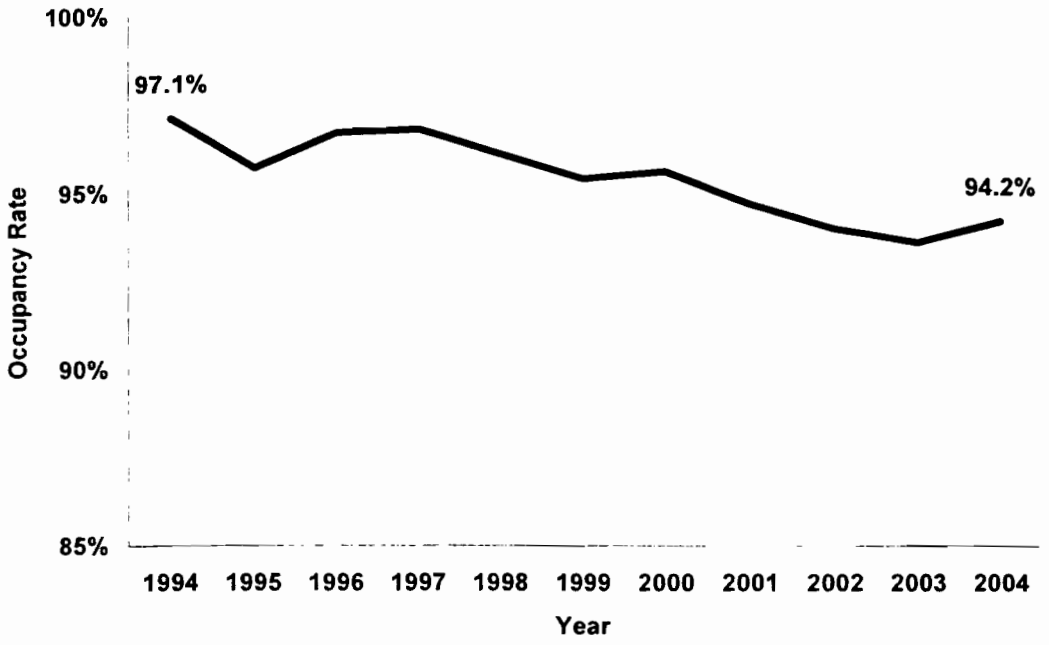
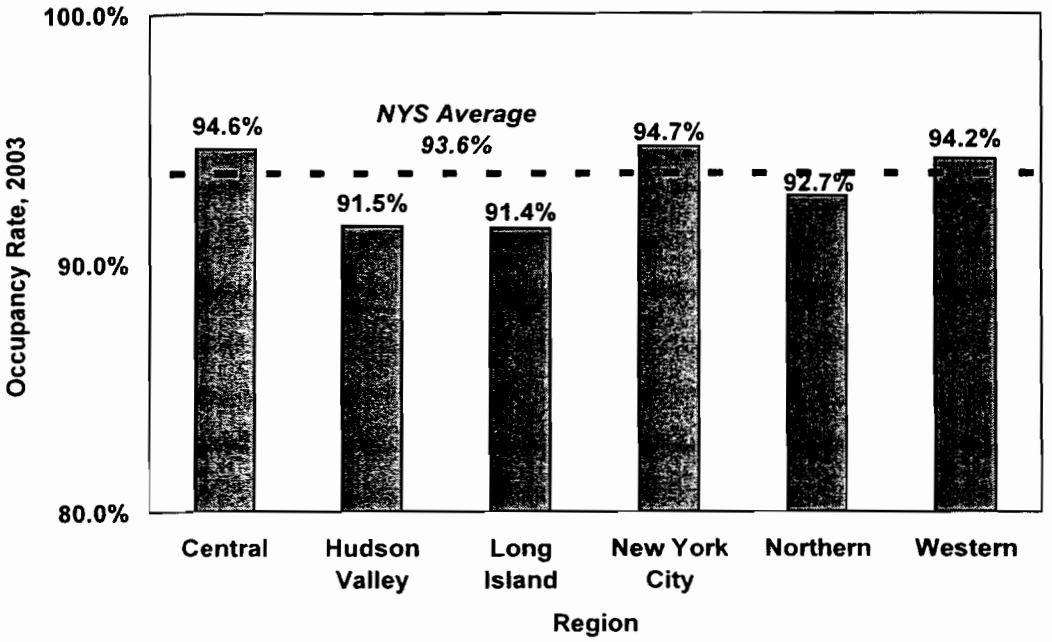


Figure 14. Nursing Home Licensed Bed Occupancy Rates by Region, 2003 (Adjusted for partial years)



Although occupancy rates have been declining, New York's nursing homes have increased the numbers of people they serve. Shorter-term stays for sub-acute care have become so prevalent that the number of total nursing home admissions has more than doubled since 1997. The rapid growth of sub-acute services, together with rapid resident turnover rates (less than 30 days length-of-stay), reduces the occupancy of an efficient provider. The State's nursing home average length of stay decreased from approximately one year in 1997 to 217 days in 2003. Patient turnover leads to vacant beds due to admission/discharge timing issues, the need to match roommate gender and other factors.

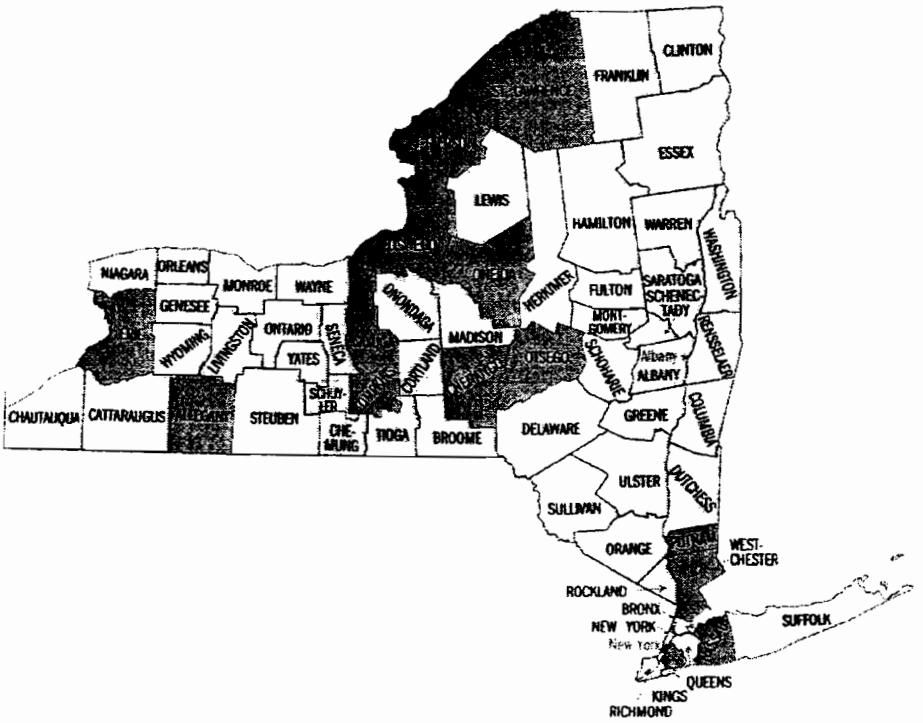
According to the 2007 New York State residential health care facility bed need methodology, the State has roughly the right number of beds. In the aggregate, the supply is roughly equivalent to need, with about 2,000 beds still needed statewide. However, this analysis is based on current utilization patterns. Many trends could only further strengthen the need to shift future resources. For example, progress in medical treatment and technology has enabled many older New Yorkers to live longer in less restricted settings. Though the population is

gradually aging, the shift to home and community-based care could keep pace with this trend, particularly as baby boomers turn away from institutional care settings.

The bed need methodology also reveals that nursing home beds are unevenly distributed across the state. The methodology indicates that the Bronx, New York (Manhattan), Westchester, Schenectady, St. Lawrence, Oneida, Monroe, Chatauqua, and Albany counties have too many beds. Notably, the bed need methodology does not tell the whole picture; even in counties with a calculated deficit of beds, the county occupancy remains quite low, indicating over-bedding. These counties include Cayuga, Jefferson, Westchester, Putnam, and Columbia.

The Commission also considered the relative availability of non-institutional long-term care alternatives, such as adult day health care, long-term home care, and supportive housing, in determining whether there was excess capacity in the nursing home sector. If a county has a high occupancy but few home- and community-based options, it is likely that the nursing home beds are utilized by individuals who may otherwise be cared for in an alternate setting, if it existed. After examining the State's bed need methodology and figures, county nursing home occupancy, and availability of non-institutional care alternatives, several counties emerge as high-priorities for resource shifts:

Figure 15. New York State Counties with LTC Resource Shift Opportunities



New York State Has Too Few Home- and Community-Based Alternatives to Nursing Homes

Regardless of nursing home bed availability, the state has an insufficient supply of non-institutional alternatives. Many additional "slots" of adult day health care, long-term home health care, and supportive housing are needed. In the majority of counties, the existing supply of such alternative services meets less than half of the total calculated need. As a result, some residents who do not require institutional care are institutionalized because there are no available alternatives for them. The shortage of non-institutional slots is more severe in upstate and rural areas of the state.

A combination of surplus nursing home beds together with a need for non-institutional services creates an opportunity to shift resources from facilities to alternatives. For example, New York State's own rightsizing demonstration permitted nursing home beds to be permanently de-certified and exchanged for other certified capacity, including adult day health care, long-term home health care, and Medicaid-supported Assisted Living Program (ALP) beds. As many as 2,500 nursing home beds were eligible for conversion under this demonstration.

Shifting resources to non-institutional care requires certain factors to be in place. Limiting factors may be insufficient supplies of affordable and accessible senior housing, and limited workforce availability such as qualified home care attendants. Thus, it is consistent that many States with rightsizing initiatives have focused on creating more assisted living, supportive housing, and other congregate care options that can be more staff-efficient. Additionally, investment and support of technology and informal caregivers can make shifting resources out of nursing homes more viable.

What's Wrong With Excess Capacity?

A surplus of beds threatens quality of care, promotes inefficiencies, increases costs, threatens the provision of public goods, and contributes to the fragile finances of health care providers. In many other industries, the cost of excess capacity is borne by the institution or corporation itself. In health care delivery, however, a large portion of excess capacity falls on the tax-paying public, due to the presence of Medicare, Medicaid, and other public health

payors.[59] The heavy public cost of unneeded beds has prompted state and federal lawmakers to concentrate on elimination of excess capacity. For example, former Congressional Representative Pete Stark, stated "Low occupancy is a symptom of the indulgent spending spree the Country's hospitals have been on," and Gail Wilensky, former Administrator of the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) suggested that four out of every ten empty staffed hospital beds should be reduced.[60] "[P]ressure to fill empty beds puts hospitals at a disadvantage in negotiating rates with payers and the widespread availability of beds means that physicians have few incentives to shorten the length of stay of their patients. Most importantly, the oversupply means that the industry is not generating enough revenue to adequately cover its fixed costs."[61]

Excess Capacity Jeopardizes Quality of Care

In health care, there is a direct positive relationship between volume and outcomes. The more cases or procedures performed by a hospital or physician, the better the quality of care. A review of 135 studies found that 71% of studies of hospital volume and 69% of studies of physician volume reported statistically significant associations between higher volume and better outcomes.[62] It is a public health imperative to concentrate higher volumes at fewer institutions to improve patient care. For this reason, New York and many other states establish minimum volume thresholds below which hospitals may not perform certain advanced procedures. Excess capacity in the hospital system disperses volume and expertise while potentially diminishing quality care.

Excess capacity also subsidizes inferior care by blocking necessary investments. Facilities have less chance of attracting the best doctors, buying and maintaining the latest equipment, and maintaining adequate nurse staffing when they must devote inordinate resources to preserving old, underused physical plants. With fewer resources to spend on equipment, salaries, and new technologies, the quality of care suffers.

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[59] Gaynor, M., & Anderson, G.F. (1995). Uncertain demand, the structure of hospital costs, and cost of empty hospital beds. *Journal of Health Economics. 14 (3)*, 292.

[60] Ibid, p. 293.

[61] Advisory Commission on Hospitals (1999). Report of the Advisory Commission on Hospitals. Retrieved September 22, 2006, from New Jersey Department of Health and Senior Services Web site: http://www.state.nj.us/health/hcsa/acoh/trends.htm

[62] Halm, E.A., Lee, C., & Chassin, M.R. (2002). Is volume related to outcome in health care? A systemic review and methodologic critique of the literature. *Annals of Internal Medicine. 137*, 511-520.

Excess Capacity Promotes Unnecessary Utilization of Services

It is well documented that hospitalizations expand in relation to number of beds available. Capacity generates utilization so that a bed built is a bed filled, a phenomenon often called Roemer's law. Similarly, greater numbers of expensive tests and procedures are performed when resources like imaging machines, diagnostic labs, and surgical suites are available and need to be paid for. Areas with excess capacity repeatedly demonstrate higher rates of hospital admission, greater numbers of patient days, and surgeries; differences that cannot be explained by differences in rates of illness or age according to the Dartmouth Atlas of Health Care.[63] "In situations where there is excess capacity, the body of evidence suggests that physicians tend to utilize more [medically unnecessary] procedures...Studies have found similar relationships in physician supply-to-utilization patterns (such as between supplies of cardiologists and invasive heart procedures) and high-tech equipment-to-utilization patterns. It appears that much of the unwanted variation in hospitalization rates, use of procedures, and intensity of care is directly attributable to the differences across geographic areas in physicians, technology and beds per capita."[64]

Similar patterns occur among nursing homes that are struggling to fill excess beds and qualify for bed-hold payments. To maintain occupancy levels, nursing homes may admit less-intensive residents who do not require such round the clock skilled care. But doing so can not only negatively impact the facility's Medicaid rate by lowering its case mix index; it can also institutionalize individuals that could have their needs met in a less-restrictive alternative.

Excess Capacity Duplicates Services and Hinders Collaboration

When capacity exceeds community need, health care providers must compete vigorously to maintain a viable market share. For instance, prior to the reduction of services at St. Mary's Hospital in 1999 and the closure of the Genesee Hospital in 2001, Rochester area hospitals were operating at less than 70% occupancy, and perceived the need to engage in competitive but non-productive activities such as advertising. Hospitals felt compelled to purchase physician

[63] Center for the Evaluative Clinical Sciences. (2005). Supply-Sensitive Care. Retrieved September 22, 2006, from Dartmouth Atlas Project Brief Web site: http://www.dartmouthatlas.org/topics/supply_sensitive.pdf

[64] Finger Lakes Health Systems Agency. (2005). *Capacity Matters*. 1-16. Rochester: Finger Lakes Health Systems Agency.

practices, a financially draining strategy, in an effort to lock in or capture market share. Instead of joint services, hospitals instead concluded they must have enough capacity to satisfy their individual sought-after market share. For instance, hoping to gain market share, in the last half of the 1990s each hospital system in Monroe County developed new obstetric units for more births than they historically experienced; the result was an excess of obstetric capacity which lasted until the closure of the Genesee Hospital.[65]

Today, New York's providers continue to compete with another in a "medical arms race." To attract both physicians and patients, they feel compelled to seek the most sophisticated technologies and specialties that generate higher reimbursement rates and financial margins. The result is unnecessary duplication of services, especially of costly high-end services like magnetic resonance imaging, cardiac catheterization, and transplant centers, and too little integration of regional service delivery. Elimination of systemic redundancies could save money without compromising access to care.

Excess Capacity Threatens Safety Net Services

Low occupancy rates and the associated financial pressures on hospitals can lessen hospitals' commitments to provide care for vulnerable populations. Hospitals in financial trouble may be forced to retrench, resulting in potential loss of access to care. As fiscal pressures increase, facilities may be inclined to close or shrink their less financially viable services in inner city neighborhoods or in rural communities.

Excess Capacity Increases Costs

Excess capacity is expensive to maintain. Despite the dramatic shift to outpatient care, the costs of maintaining a "bricks and mortar" based health system hang like an albatross around the neck of New York's providers and taxpayers. Even beds, wards, or buildings that are unused and unstaffed represent fixed costs that must still be paid and thus spread over a dwindling number of patients and other over all other services at that particular facility. Additionally, dollars spent in retiring capital debt of a given facility are not available for other productive uses. Finally, dollars spent on duplicative service capacity caused by excess capacity cannot be then captured and reinvested to fill community needs.

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[65] Ibid